PM Form 3.3.1

ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES

I. Information on Person Making Referral Today's Date and Time_____

Name and Title_____

Affiliated Agency_____Phone_____Fax_____

Relationship with Person Being Referred_____

II. Information on Person Being Referred for Services

Name_____ Date of Birth _____Age_____ Gender ☐ F ☐ M

Address_____

City_____ State_____ Zip_____ Phone_____

Parent/Legal Guardian (if applicable)_____Phone_____

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person (include phone)_____

Person/Parent/Guardian is aware of referral: ☐No ☐Yes

Cultural and language considerations ☐No ☐Yes, specify language/need_____

Special Needs:

Mobility Assistance ☐No ☐Yes, identify assistance needed_____
Visual Impairment Assistance ☐No ☐Yes, identify assistance needed_____
Hearing Impairment Assistance ☐No ☐Yes, identify assistance needed_____
Cognitive Impairment ☐No ☐Yes, identify assistance needed_____

Payment Source: ☐ AHCCCS ID #_____ ☐ Private insurance_____ ☐ Medicare
☐ Self pay ☐ Health Plan_____
PCP_____ Phone_____ Fax_____

Check any of the following which pertain to the person being referred:

☐ Shows evidence of suicidal or homicidal thoughts or behaviors ☐ Identified need for psychotropic medications
☐ Pregnant Woman ☐ Is currently hospitalized ☐ Was recently discharged from an inpatient setting
☐ Has immediate medical needs ☐ Other potential risk factors, e.g., dehydrated, malnourished, homeless

Reason for Referral, including an explanation of any items checked above_____
_____

Additional information and contact information _____
_____

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? ☐ Yes ☐ No, if no, when will she/he exhaust the current supply of medications_____

III. Information to Be Completed by T/RBHA/Provider

Date / Time Received _____

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care:_____

Type of Appointment ☐ Immediate ☐ Urgent ☐ Routine
☐ Available Intake Appointment Offered, specify date, time, place_____
Action Taken
☐ Scheduled Intake Appointment, specify date, time, place_____
☐ Not Referred for Appointment, specify why_____

☐ Other Disposition, explain _____